

SUBCOMMITTEE NO. 3

Agenda

Health, Human Services, Labor & Veteran's Affairs

Chair, Senator Elaine K. Alquist

Senator Alex Padilla
Senator Dave Cogdill



April 16, 2006

(Upon Adjournment of Senate Session)

Room 3191
(John L. Burton Hearing Room)

(Diane Van Maren)

<u>Item</u>	<u>Department</u>
4265	Department of Public Health—Selected Issues
4260	Department of Health Care Services—Selected Issues

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible.

A. ISSUES FOR “Vote Only” for Both Departments (DHCS & DPH)
(Item 1 through Item 10) (Pages 2 through 10)

1. Elimination of “Price Adjustment--Department of Health Care Services (DHCS)”

Issue—Finance Letter. The Subcommittee is in receipt of a Finance Letter requesting to reduce the Department of Health Care Service’s administrative budget by a total of \$714,000 (General Fund) to reflect the elimination of the “price adjustment” originally funded in the Governor’s budget released on January 10, 2007. This action is simply eliminating the augmentation provided in January.

The Administration states that they are eliminating this “price adjustment” (in essence a cost-of-living-adjustment) for state support (primarily for operating expenses) to provide for expenditure increases they are requesting through the Finance Letter (spring revision) process.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the Finance Letter and make the requested reduction. This is a minor adjustment to the State Support budget. No issues have been raised.

2. Elimination of “Price Adjustment--Department of Public Health (DPH)”

Issue—Finance Letter. The Subcommittee is in receipt of a Finance Letter requesting to reduce the Department of Public Health’s administrative budget by a total of \$485,000 (General Fund) to reflect the elimination of the “price adjustment” originally funded in the Governor’s budget released on January 10, 2007. This action is simply eliminating the augmentation provided in January.

The Administration states that they are eliminating this “price adjustment” (in essence a cost-of-living-adjustment) for state support (primarily for operating expenses) to provide for expenditure increases they are requesting through the Finance Letter (spring revision) process.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the Finance Letter and make the requested reduction. This is a minor adjustment to the State Support budget. No issues have been raised.

3. Richmond Laboratory—Capitol Outlay (Department of Public Health--DPH)

Issue—Finance Letter. The Subcommittee is in receipt of a Finance Letter requesting an increase of \$482,000 (General Fund) and Budget Bill Language for preliminary plans and working drawing phases to upgrade the “Viral and Rickettsial Disease Laboratory located at the state’s Richmond Laboratory campus. This proposed upgrade is needed in order to meet federal guidelines related to Biosafety Level III laboratories as determined by the U.S. Department of Agriculture, Centers for Disease Control and Prevention, and National Institutes for Health.

The DPH states that this upgrade is necessary to meet new federal guidelines for safely working with highly pathogenic influenza viruses. **The DPH states that this project will provide an appropriate environment for the identification and handling of avian influenza viruses and other pathogens brought into the state.**

It should be noted that the Finance Letter only requests funding for preliminary plans and working drawings. The construction phase is estimated to cost \$2.520 million and will be addressed in the future.

The DPH states that the projected scope of the laboratory enhancements will require design and construction to modify the “Viral and Rickettsial Disease Laboratory located at the state’s Richmond Laboratory campus to provide the following:

- Unidirectional shower-out capability;
- Hands-free faucets;
- A pass-through autoclave sterilizer;
- An equipment decontamination area;
- HEPA filtration of the exhaust side of the HVAC system;
- Positive sealing dampers on the HVAC system and through-wall ports for the safe gaseous decontamination of the laboratory; and
- Electronic monitoring systems within the HVAC system.

Of the six laboratories at the Richmond Campus, the Viral and Rickettsial Disease Laboratory was selected for these laboratory enhancements because of its primary role as an infectious disease reference laboratory to local county and city public health laboratories for the diagnosis, identification, and isolation of viruses and Rickettsial pathogens. This laboratory also serves as a basic public health virology laboratory for counties without a public health laboratory (such as the small counties)

Subcommittee Staff Recommendation—Approve. It is recommended to approve the Finance Letter as proposed since the state should have a laboratory that meets these standards in order to appropriately address the diagnosis, identification and isolation of highly pathogenic influenza viruses. Clearly, these improvements are needed to maintain the health and safety of all involved in this work.

4. Nuclear Planning Assessment Special Account (CPI) Adjustment

Issue—Finance Letter. The Subcommittee is in receipt of a Finance Letter to increase by \$32,000 the Nuclear Planning Assessment Special Account within the Department of Public Health. This increase is required by Section 8610.5 of the Government Code which provides for a consumer price index adjustment. Total expenditures with this augmentation are \$902,000 (Nuclear Planning Assessment Special Account).

These funds are used to support the existing Nuclear Power Preparedness Program. Legislation mandating the Nuclear Power Preparedness Program has been continuous since 1979, enacted as Government Code Section 8610.5, the Radiation Protection Act. The program is funded by utilities through a special assessment fund managed through the State Controller.

While the state Office of Emergency Services has absolute coordination authority during emergency response, the Department of Public is assigned the technical lead responsibility during ingestion pathway and recovery phases of an emergency. The goal during ingestion pathway response is preventing contaminated water, food, and food animals from reaching the consumer. The goal during recovery is restoring areas to pre-accident conditions.

In California there are two operating nuclear power plant sites—Diablo Canyon (San Luis Obispo) and San Onofre Nuclear Generating Station (San Diego).

Subcommittee Staff Recommendation—Approve. This is simply a technical adjustment that conforms to existing law. No issues have been raised.

5. X-Ray Inspection Staffing

Issue. The Department of Public Health (DPH) is responsible for conducting annual X-Ray machine inspections. The budget proposes an increase of \$984,000 (Radiation Control Fund) to fund eight Associate Health Physicists to conduct X-Ray Machine inspections to help ensure the machines do not pose a public and worker health hazard and that they are used safely. The Administration states that each of these inspectors will conduct 300 annual inspections, for a total of about 2,400 additional inspections annually.

According to the department, 9,000 inspections must be conducted annually (Inspection rates vary depending on the type of X-Ray machine). Presently, there are 18 inspectors who perform 5,400 inspections annually. Therefore, there are about 3,600 inspections that are not being performed due to additional workload increases (i.e., more machines) and inadequate staffing levels.

The DPH notes that anticipated efficiencies through the use of new technologies will address the work of four otherwise requested Health Physicists. These new technologies pertain to the inspection of dental X-Ray machines.

All fees from the registration of X-Ray machines are deposited into the Radiation Control Fund which is used to support X-Ray inspection and investigation actions. Based on the most recent fund condition statement, there are sufficient funds to support the requested 8 new positions.

Subcommittee Staff Recommendation—Approve. The request for these positions is reasonable and necessary to protect public health and safety, and special funds are available specifically for this purpose. No issues have been raised.

6. Administrative Support for Licensing & Certification Program

Issue. The budget proposes an increase of \$177,000 (Licensing and Certification Fund) to fund two positions—a Staff Services Analyst and an Associate Accounting Analyst—to provide administrative support to the 155.5 permanent positions authorized through the Budget Act of 2006. The purpose of these positions is to (1) conduct personnel functions, such as recruitment and hiring activities; and (2) monitor the collection of revenues from facilities and track expenditures within the Licensing & Certification (L&C) Division.

The L&C Division has 15 District Offices and one headquarters office throughout California. Presently there are 5 positions that perform the personnel and facilities operations activities for about 750 employees. The additional 155.5 positions added in the Budget Act of 2006 is a 17 percent increase in staffing. This requires additional personnel work for which the proposed Staff Services Analyst position is designated.

The Associate Accounting position would be used to track, monitor and project program revenue and expenditures, as well as reconciling the various special funds (including the L&C Fund, federal funds and citation accounting funds). In addition, this position would be used to calculate fees annually based on L&C Division surveyor workload and expenditures for over 20 categories of facilities which the state licenses and certifies.

Subcommittee Staff Recommendation—Approve. These positions are warranted given the magnitude of the changes implemented in the Licensing and Certification area, and the need to appropriately track revenues and expenditures across the entire program area. No issues have been raised.

7. Legal Support for Increased Licensing & Certification Enforcement

Issue. The budget **proposes an increase of \$711,000** (\$355,000 Licensing & Certification Fund and \$356,000 federal funds) **to fund 6.5 positions** (two-year limited-term) **to handle legal-related workload** that will flow from the 114 new Licensing and Certification (L&C) surveyor positions, and 14.5 L&C investigative staff provided in the Budget Act of 2006.

The Department of Public Health notes that the new L&C surveyor staff will increase the enforcement and disciplinary actions against licensees who are found to be in violation of L&C standards. Without sufficient legal staff resources to handle the additional workload, the department will not be able to promptly take legal actions necessary for the protection of public health and safety (such as in a facility crisis, the processing of citations and civil money penalties, license violations and the like).

The requested limited-term positions are:

- 1 Staff Counsel
- 4 Health Facility Evaluator Specialists
- 0.5 Senior Legal Typist
- 1 Staff Services Manager

These positions will be used to conduct various activities associated with notices of deficiency, appointments of temporary managers/receiverships, informal citation review conferences, procedural legal questions, and other enforcement issues.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the request given the volume of work that is likely to materialize in 2007-08 from the increases in the surveyor work. No issues have been raised.

8. Medi-Cal Community-Living Support Benefit Waiver Pilot Project

Issue. The budget proposes a total increase of **\$405,000** (\$202,000 as an intergovernmental transfer from the City and County of San Francisco, and \$203,000 federal funds) **to fund a total of 4 positions** (eighteen month limited-term) **to implement Assembly Bill 2968 (Leno), Statutes of 2006.**

The purpose of this legislation is to increase access to needed health-related and psychosocial services for eligible Medi-Cal enrollees residing in the City and County of San Francisco. Specifically, it will provide community-based alternatives to residents of Laguna Honda Hospital and Medi-Cal enrollees at-risk of institutionalization. As noted in the funding stream, San Francisco is providing matching funds for this purpose.

Three of the requested positions are for the Medi-Cal Program, within the Department of Health Care Services, to develop, implement and administer this pilot project. Two of these positions will be used to craft a federal Medicaid (Medi-Cal) Waiver for the project, while the remaining position will be used to implement quality assurance and quality improvement plans.

The remaining position—a Health Facilities Evaluator Nurse—will be assigned to the Licensing and Certification Division within the Department of Public Health. This position will have responsibility for the development, implementation, and monitoring of facilities compliance with Wavier assurances regarding the health, safety, and welfare of individuals enrolled in the Waiver.

Overall these positions will be used to work with the federal Centers for Medicare and Medicaid Services (CMS), various state departments, and the City and County of San Francisco to resolve issues regarding administration, eligibility, coverage and benefits, delivery system, access, quality assurance, cost neutrality, systems support, implementation timeframes, and reporting.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the budget request for it meets the purposes of the enabling legislation, and the workload is justified. No issues have been raised.

9. Specialty Mental Health Waiver—Department of Health Care Services Staff

Issue. The budget **proposes an increase of \$108,000** (\$54,000 Mental Health Services Account and federal funds) **to extend a Staff Services Manager I for an additional two-year period.** This position is assisting in expanding services required under the Mental Health Services Act (MHSA) in relation to the Medi-Cal Specialty Mental Health Services Consolidation Waiver. This Waiver is expected to be extended through 2009.

This position is responsible for managing work in relation to the Waiver. An extension of this position would provide for the ongoing management, supervision and staff oversight required to ensure the timely renewal of the Waiver and to manage the interagency agreement with the Department of Mental Health.

Among other things, this position does the following:

- Supervises the work of three staff related to Waiver functions;
- Oversees issues related to Waiver development, federal monitoring, cost neutrality and reporting requirements;
- Serves as liaison to the federal Centers for Medicare and Medicaid (CMS) during the Wavier review, implementation, monitoring and program evaluation process;
- Provides advice and consultation to management, other agencies, provider associations and consumer advocates regarding federal Waivers and related policies and procedures; and
- Provides linkage for the Department of Health Services Waiver operations and the MHSA process.

Subcommittee Staff Recommendation—Approve. The position would be funded using special fund moneys and the workload is justified. The Medi-Cal Specialty Mental Health Services Consolidation Waiver is a significant Waiver for the state and it is important to maintain it and potentially expand it in relation to the Mental Health Services Act. No issues have been raised.

**10. Medi-Cal Supplemental Reimbursement for Health Facilities--
Assembly Bill 959 (Frommer), Statutes of 2006**

Issue. The budget requests an increase of \$54,000 (Reimbursements from local government) to support an Associate Governmental Program Analyst to administer the expansion of the Medi-Cal Supplemental Reimbursement process for health facilities.

Assembly Bill 959 (Frommer), Statutes of 2006, expanded the definition of various facility types that could participate in two different Medi-Cal supplemental payment programs. Specifically, the legislation included county clinics and other governmental health providers to allow these providers to obtain increased federal funding without any state cost (i.e., no General Fund).

Assembly Bill 959 requires participating facilities to contract with the state to pay for the state's administrative expenses; thereby, the requested position would be funded solely by local reimbursement.

Subcommittee Staff Recommendation—Approve. No issues have been raised with this proposal.

B. ISSUES FOR DISCUSSION—Both Departments

1. AIDS Drug Assistance Program (ADAP) & Potential Trailer Bill Language

Issue. The budget proposes to continue funding for the AIDS Drug Assistance Program (ADAP) at its *current* level of \$299.4 million (\$107.6 million General Fund, \$100.9 million federal grant funds and \$90.8 million AIDS Drug Rebate Fund) to serve about 25,000 clients. **In addition, constituency groups are seeking trailer bill language changes to address concerns with providing flexibility in making changes to the ADAP formulary.**

Each of these issues is discussed separately below.

First, the budget proposes to continue the same level of funding for the ADAP in 2007-08, as presently provided in the current year (i.e., no fiscal change). The Office of AIDS states that this estimate is based on using a new forecasting model referred to as the “New Drug Cost Worksheet Model” for projecting expenditures for 2007-08.

This new forecasting model, which is based on the federal Health Research Services Administration (HRSA) budgeting tool, should be more accurate than past regression models that were used. Specifically, this new model begins with the previous year’s local assistance drug costs and identifies factors (or changes to the program) that are likely to have a fiscal impact. For each factor, there is a corresponding increase or decrease to the budget.

The Office of AIDS notes that because they are using a new model of forecasting, they are monitoring all ADAP drug expenditures on a monthly basis to determine the model’s accuracy and viability as a forecasting tool. **Therefore, there may be a need to make adjustments at the May Revision.**

Second, constituency groups have been working with staff to craft language to exempt the AIDS Drug Assistance Program (ADAP) from the Administrative Procedures Act to add or delete drugs from the ADAP formulary.

An exemption from the Administrative Procedures Act would enable the program to adjust the formulary in response to new generic drugs becoming available, the need for restrictions on the use/prescribing of some drugs, and the need to delete drugs when newer more efficacious drugs are added to the formulary. (The formulary includes a wide variety of drugs due to secondary infections and other medical issues associated with HIV infection and AIDS.)

According to the department, on average, it takes 12 months to complete the emergency rulemaking process and at least 18 months to complete the regular rulemaking process. Therefore, the ADAP formulary would not be as responsive to serving clients appropriately, and the budget could be adjusted more appropriately, including the collection of drug rebate funds from manufacturers

As noted in the language below, the ADAP would still continue to use the ADAP Medical Advisory Committee to discuss and advice on changes to the ADAP formulary. In addition, the Legislature would receive timely notification (within 15 days) of any changes.

It should also be noted that the Medi-Cal Program already *has* a statutory exemption from the Administrative Procedures Act to add or delete drugs on the Medi-Cal formulary.

The proposed language is below (underlining displays proposed changes).

Amend Health and Safety Code Section 120955 (a) (2) as follows:

The Director, in consultation with the AIDS Drug Advisory Program Medical Advisory Committee, shall develop, maintain, and update as necessary a list of drugs to be provided under this program. The list shall be exempt from the requirements of the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law. In addition, the Director shall notify the fiscal and policy committees of the Legislature of any additions, deletions or restrictions to the list within 15 business days of the action. At a minimum, this notification shall describe the specific change to the formulary, the reason for the action taken, the estimated number of people it may affect, and any estimate of costs or savings where applicable.

Background—How Does the AIDS Drug Assistance Program Serve Clients? ADAP is a subsidy program for low and moderate income persons with HIV/AIDS who have no health care coverage for prescription drugs and are *not* eligible for “no-cost” Medi-Cal Program.

ADAP clients with incomes between \$39,200 (400 percent of poverty) and \$50,000 are charged monthly co-pays for their drug coverage. A typical client’s co-payment obligation is calculated using the client’s taxable income from a tax return. The client’s co-payment is the lesser of (1) twice their annual state income tax liability, less funds expended by the person for health insurance premiums, or (2) the cost of the drugs.

Under the program, eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor. The state provides reimbursement for drug therapies listed on the ADAP formulary (over 150 drugs). The formulary includes anti-retrovirals, opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics. Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Anti-retroviral Treatment (HAART) which minimally includes three different anti-viral drugs.

Background—ADAP Uses a Pharmacy Benefit Manager. Beginning in 1997, the DHS contracted with a pharmacy benefit manager (PBM) to centralize the purchase and distribution of drugs under ADAP. Presently there are over 240 ADAP enrollment sites and over 3,300 pharmacies available to clients located throughout the state.

Background—Cost Benefit of the AIDS Drug Assistance Program (ADAP). ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible or (2) spend down their assets to qualify for Medi-Cal. About 50 percent of Medi-Cal costs are borne by the state, as compared to only 28 percent of ADAP costs.

Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, and increases the HIV-infected person's health and productivity.

Background—ADAP Drug Rebates (Federal and State Supplemental). Both federal and state law require ADAP drug manufacturer rebates to be paid in accordance with the same formula by which state Medicaid (Medi-Cal) programs are paid rebates. This formula is established by the federal CMS.

California also negotiates additional supplemental rebates under ADAP via a special national taskforce, along with eight other states. The mission of this taskforce is to secure additional rebates from eight manufacturers of anti-retroviral drugs (i.e., the most expensive and essential treatment therapies). The DHS has also begun to negotiate supplemental rebates on non-antiretroviral drugs.

Subcommittee Staff Recommendation—Approve Budget & Adopt Trailer Language. It is recommended to adopt the Governor's budgeted amount for the AIDS Drug Assistance Program (ADAP) and to adopt the trailer bill language as crafted working with constituency groups. The proposed funding level is reasonable and the language is needed in order to ensure that the ADAP formulary is current and that applicable medical uses can be maintained.

Questions. The Subcommittee has requested the Department of Public Health, Office of AIDS, to respond to the following questions.

1. Office of AIDS, Please briefly describe the program, and the budget request.
2. Office of AIDS, Please comment on the proposed trailer bill language drafted by constituency groups and staff.

2. Local Assistance Funding for Name-Based HIV Reporting Activities

Issue. Local assistance funding provided by the state to Local Health Jurisdictions for HIV/AIDS surveillance and epidemiologic studies is proposed to total \$9.7 million (\$9.1 million General Fund and \$2 million federal funds) for 2007-08. This reflects an increase of \$2 million (General Fund) over the current year.

An increase of \$2 million (General Fund) is proposed to provide an accelerated HIV reporting effort in the 62 Local Health Jurisdictions as directed by Senate Bill 699 (Soto), Statutes of 2006. The Administration states it is their intent to provide this funding for the next three fiscal years (2007-08, 2008-09 and 2009-2010).

According to the Department of Public Health, the \$2 million would be allocated to the top 11 counties/city with the highest number of reported non-name code HIV cases and cumulative AIDS cases in the HIV/AIDS case registry. These top 11 areas represent 86 percent of California's HIV/AIDS cases.

The funds would be provided as an augmentation to each of these counties' baseline surveillance budget. **The table below displays the proposed allocation of the \$2 million augmentation.** Surveillance funding for the remaining areas of the state would remain the same.

Table: Proposed Allocation for HIV Names Reporting (\$2 million)

Local Health Jurisdiction	HIV/AIDS Cases	Percentage	Funds Allocated
Los Angeles County	58,571	37.58%	\$710,817
San Francisco City/County	32,819	21.05	\$398,291
San Diego County	17,642	11.32	\$214,103
Orange County	8,913	5.72	\$108,168
Alameda County	7,833	5.03	\$95,061
Riverside County	6,775	4.35	\$82,221
City of Long Beach	6,508	4.18	\$78,981
Santa Clara County	4,664	2.99	\$78,089
San Bernardino County	4,644	2.98	\$78,089
Sacramento County	4,195	2.69	\$78,089
Contra Costa County	3,309	2.12	\$78,089
Total	155,873	100%	\$2,000,000

SB 699, Statutes of 2006, makes HIV infection reportable by name and requires health care providers and laboratories to provide this information to Local Health Jurisdictions. It also requires local health jurisdictions to report unduplicated HIV cases to the Department of Public Health. Previously, HIV infections were reported to the state using a non-name code instead of a patient's name.

SB 699, Statutes of 2006, was the result of changes at the federal level which would affect California's receipt of federal Ryan White CARE Act funds. Specifically, the federal government declared that HIV data would not be accepted unless it was reported

by name. Starting in federal fiscal year 2007, HIV counts in addition to AIDS counts will be used to allocate Ryan White CARE Act moneys to states. California presently receives about \$122 million in Ryan White CARE Act Title II funds. **Without the implementation of SB 699, California is at risk of losing about \$50 million in these federal funds annually. An accelerated HIV reporting effort will assist California in avoiding federal grant reductions.**

According to the department, each local health jurisdiction's HIV/AIDS surveillance program will be responsible for developing a performance measured plan based on state requirements and specific federal guidelines. The department will provide technical training where needed and will monitor the progress of implementation.

Background--- Overview of HIV/AIDS Surveillance. The Office of AIDS, within the Department of Public Health, is the lead state agency in California for coordination of care, treatment, and prevention strategies addressing the HIV/AIDS epidemic. The Office of AIDS maintains the statewide registry of AIDS and HIV cases and provides statewide coordination of case reporting throughout California. Staff from the state, including communicable disease investigators, information technology staff, and researchers visit all Local Health Jurisdictions to review and observe program operations, assess security and confidentiality practices, provide training, and provide feedback the locality's surveillance efforts. Local assistance funds are allocated to Local Health Jurisdictions for HIV/AIDS surveillance activities.

Subcommittee Staff Recommendation—Approve. The department has developed an approach for implementation that is reasonable and has the consensus of constituency groups. These funds are needed in order to meet federal requirements and to help ensure that California can retain its appropriate share of federal funds through the Ryan White CARE Act.

Questions. The Subcommittee has requested the Department of Public Health to respond to the following questions.

1. Department, Please provide a brief summary of the budget request and how the determination was made to allocate the funds in this manner.
2. Department, Is California at risk for losing any federal Ryan White CARE Act funds at present or will our implementation of SB 699 facilitate maintaining all of our funding?

3. Medi-Cal Managed Care Rates—Multiple Issues on Rate Structure

Issue. Significant questions regarding the existing Medi-Cal Managed Care rate structure have been evolving for several years. As noted by various constituency groups, reports, and even by the DHCS who administers the Medi-Cal Managed Care Program, the existing rate methodology is outdated. **A rational approach to establishing the rates needs to be crafted and applied *equability* across health plans participating in Medi-Cal Managed Care.**

Issues abound as to the methodology and “actuarially” soundness of the rates paid under the state’s Medi-Cal Program, both in the Fee-For-Service Program and in Medi-Cal Managed Care.

Many of these issues have evolved over time due to **(1)** incomplete, inaccurate and unreliable data for which to base rates on, **(2)** establishing rates based upon the availability of General Fund support, **(3)** varying definitions of what constitutes “actuarial” soundness, **(4)** a lack of clarity on how to link quality of care with rates, **(5)** difficulties in discerning health plan financial viability, and profit margin factors, **(6)** a need to trend data in an accurate manner, and many, many others.

Background—Key Recommendations from the Mercer Report. The DHCS contracted with Mercer to conduct an analysis regarding Medi-Cal Managed Care Program rates. The key recommendations contained within the Mercer Report (released February 2007 to the Legislature) are as follows:

- Use health plan encounter data and supplemental cost data submitted by the plans in conjunction with other data/information as the base source data for rate development efforts. Improve the usefulness of financial reporting from the contracted health plans by implementing a Medi-Cal specific financial reporting requirement.
- Develop a county or health plan model specific rate development process: (1) Two Plan; (2) GMC; (3) County Organized Healthcare System. Utilize Two Plan Model data for Two Plan Model rate development, COHS for COHS and GMC for GMC. In addition to increasing the underlying data representation by contract type, it would also decrease capitation rate reliance upon a small percentage of the total managed care population. Area/geographic adjustment factors could also be moderated under this scenario.
- Conduct detailed reviews of health plan financial statements to identify appropriate costs and/or other factors for use in developing rates.
 - Validation Tool for encounter and supplemental data;
 - Indicator for efficient plans
- Consider use of maternity supplemental payment method to cover the cost of all deliveries. Use normalized risk.
- Reflect the Administrative Allowance as a percentage of the capitation payment.

- Utilize a combined underwriting profit/risk/contingency.
 - Assumption Range: 2 percent to 4 percent
 - Most government programs are closer to 2 percent
- Develop a mechanism to measure the relative risk of each health plan in order to identify adverse/positive selection.
- Consider use of performance incentives to reward better plan performance.

The DHCS states that they *may be forthcoming* at the Governor's May Revision to address some of these issues and begin to incorporate both short-term changes and a longer-term strategy to continue the viability of the Medi-Cal Managed Care Program, particularly within the context of health care reform.

Background—Existing Medi-Cal Managed Care Rate Structure. Though the DHS did change its rate methodology in order to meet federal law requirements to be “actuarially” based, amongst other things, the DHS does not use encounter data to make rate determinations.

The “base cost” is the part of the rate that relates to experience from the past. Generally, to calculate the base cost, an attempt is made to find a group of individuals that will be similar to the group for which the rates are being set. Claims tapes for four COHS's is used for determining the Two Plan Model rates. Therefore, the base data set used for this process is comprised of only 8 percent of the Medi-Cal managed care membership.

Various adjustment factors are applied to the base costs, such as for age/sex population mix, enrollee's duration of Medi-Cal enrollment, trend factors for hospital inpatient and outpatient services, trend factors for pharmacy, and other factors. In addition, changes made through the state budget process are also to be factored in as part of the process.

The DHCS has established capitated rates using this process for six eligibility aid codes as follows: (1) Family; (2) Disabled; (3) Aged; (4) Adult; (5) AIDS; (6) Breast and Cervical Cancer Treatment Program. In addition, as a result of the Medicare Part D, there has been an additional three codes added to this (Disabled, Aged and AIDS are separated into “with Medicare” and “without Medicare”).

Currently there are contract provisions that provide for an administrative remedy and an appeals process when disputes are raised by the plans regarding contract issues. These provisions are included in the Two Plan Model, Geographic Managed Care and the COHS contracts. Specifically, there is (1) an initial “notice of dispute” process, (2) an administrative appeals process, and (3) a Writ of Mandate process which is filed with the Superior Court to protest the Administrative Appeal decision. Within the last two-years, 15 plans have filed some form of Administrative Appeal regarding rates. Four cases have been taken to Superior Court.

Background—Budget Act of 2006. The Budget Act of 2006 made two adjustments to the rates paid to Managed Care plans. **First**, a 5 percent rated reduction required by AB 1762, Statutes of 2003 (Omnibus Health Trailer), sunset as of December 2006 (was in effect from January 1, 2004 through December 31, 2006). As such, an adjustment was made to restore this reduction.

Second, the DHCS conducted a financial review of the 22 Managed Care plans to determine fiscal solvency (as it pertained to “tangible net equity”—TNE). Based on the DHCS review and their criterion, 6 plans received rate increases. These included the following: Central Coasts Alliance for Health (COHS); Health Plan of San Mateo (COHS); Partnership Health Plan (COHS); Santa Barbara Health Authority (COHS); Contra Costa Health Plan (COHS); and San Diego Community Health Group (Geographic).

Background—5 Percent Rate Reduction From Prior Years. All Medi-Cal Managed Care Plans were affected by an actuarially equivalent 5 percent rate reduction effective January 1, 2004 through December 31, 2006.

Background—Quality Improvement Assessment Fee Rate Increase. Medi-Cal Managed Care Plans, except for COHS’, are participating in the “Quality Improvement Assessment” fee effective as of July 1, 2005. This arrangement enables plans to pay the state a fee (6 percent) that is then matched with federal funds to provide a rate increase. The state was able to offset General Fund expenditures from this arrangement as well. This arrangement enabled plans to receive about a 3 percent increase on average. This program is scheduled to end by 2009 due to recent changes in federal law.

Background—Loss of Confidence in Rate Calculations as Managed Care Expanded. When Managed Care plans became part of the program, the state’s obligation and method of payment changed. The state now had to begin paying a fix amount per member to a health plan each month, and the health plan would agree to pay for the member’s medical care. At this time, the federal CMS imposed a requirement that payments to managed care plans could not exceed, in the aggregate, what the state would have spent had the individuals remained in Fee-For-Service.

By the end of 1997, a major portion of Medi-Cal eligibles were enrolled in Managed Care plans. As such, the rate calculations for Managed Care plans had to be changed because of the loss of sufficient Fee-For-Service data. The validity of the data was compromised.

The decision was made to create a new methodology for the Two Plan Model that would place less emphasis on Fee-For-Service cost data, and gradually move to a methodology based on managed care encounter data.

Background—Expansion of Medi-Cal Managed Care to Additional Counties. Through the Budget Act of 2005, the Legislature approved for the DHCS to work with health plans to expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment is to include the mandatory enrollment of families and children linked to CalWORKS, and the voluntary enrollment of aged, blind and

disabled populations (i.e., as presently done under the existing Medi-Cal Managed Care Program).

It should be noted that the Administration's original schedule for expansion into these counties has changed considerably. Originally the Administration believed expansion would occur by April 2008; however this has now been updated to extend to July 2009 (for the last county of expansion). It should be noted that any expansion needs to be done well, and not rushed. **However, the development of appropriate rates for this expansion to occur has been one of the issues that have required a longer roll out of this effort.**

Background—Overview of Medi-Cal Managed Care. The DHCS is the largest purchaser of managed health care services in California with over 3.2 million enrollees, or about 50 percent of enrollees, in contracting health plans.

The state's Managed Care Program now covers 22 counties through three types of contract models—Two Plan Managed Care, Geographic Managed Care, and County Organized Health Systems (COHS). Twenty health plans have contracts with Medi-Cal within the 22 counties. Some of the plans—like commercial plans—contract with Medi-Cal under more than one model (i.e., commercial plan in Two Plan Model and participate in the Geographic Managed Care model for example).

For people with disabilities, enrollment is mandatory in the County Organized Health Systems, and voluntary in the Two Plan model and Geographic Managed Care model. About 280,000 individuals with disabilities are enrolled in a Medi-Cal Managed Care plan.

Each of these models is briefly described below.

- **Two-Plan Model.** The Two Plan Model was designed in the 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.
- **Geographic Managed Care Model.** The Geographic Managed Care model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. Sacramento and San Diego counties contract with nine health plans that serve about 11 percent of all Medi-Cal managed care enrollees in California.

It should be noted that the capitation rates for each of the health plans participating in the Geographic Managed Care model are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each health plan. Only those individuals on the CMAC, including the DOF and DHS, know the capitation rates.

- County Organized Healthy Systems (COHS). Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for **all** Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher costs aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models. About 550,000 Medi-Cal recipients receive care from these plans. This accounts for about 16 percent of Medi-Cal Managed Care enrollees.

It should be noted that the capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in said county. Only those individuals on the CMAC, including the DOF and DHS, know the capitation rates.

Constituency Concerns. The Subcommittee is in receipt of several letters expressing continued concerns regarding the rate structure utilized within the Medi-Cal Managed Care Program and the amount of reimbursement rate paid. Among other things, these concerns include the following:

- Accounting for hospital costs, particularly when the CA Medical Assistance Commission negotiates rate increases for hospitals and then the DHCS does not account for these rate increases within the Medi-Cal Managed Care Program.
- Disconnect between the DHCS and the CA Medical Assistance Commission in how rates are established for certain plans (four of the COHS and both Geographic Managed Care plans) that presently must cross-walk between the two entities.
- Lack of clarity in how rates are established overall, including considerations of medical inflation and tangible net equity levels (fiscal solvency), as well as specialty care services needed for aged, blind and disabled individuals (such as for the COHS).
- Lack of timeliness in establishing rates. The DHCS often does not establish rates until well after (sometimes as long as six to eight months) the fiscal year for the health plans contracts has begun. For example, the most recent capitation rate manual for the Two-Plan Model was just released as of March 6, 2007 for the rates being paid from October 1, 2006 through September 30, 2007.
- Concern with how “budget adjustment factors” are applied by the DHCS to the Medi-Cal Managed Care rates. Through the budget process, decisions are made that affect expenditures within the overall Medi-Cal Program. As part of their rate-setting process, the DHCS takes into consideration these “budget adjustment factors”. Several health care plans believe these adjustments are not “actuarially” sound.

Subcommittee Staff Recommendation—Hold Open Pending May Revision.

Significant issues regarding the structure of the Medi-Cal Managed Care rate reimbursement system continue to be of concern. At this time, it is recommended to hold this issue open pending the receipt of the May Revision and further discussions with constituency groups as well as the Administration.

However, at a minimum, the Subcommittee should consider the crafting of trailer bill legislation to begin to build upon a more definitive structure for the development of rates within Medi-Cal Managed Care.

Questions. The Subcommittee has requested the Medi-Cal Program to respond to the following questions.

1. DHCS, Please provide a brief description of how the rates for Medi-Cal Managed Care plans are now constructed.
2. DHCS, Please provide a brief description of the key aspects contained in the Mercer analysis.
3. DHCS, What next steps are necessary in order to craft more rational rates for the Medi-Cal Managed Care Program?

4. Medi-Cal Program-- County Performance Measures & Trailer Bill Language

Issue. The Administration is proposing trailer bill language to change its agreement with the counties regarding performance measures used to administer Medi-Cal eligibility processing. **Specifically, they are seeking to increase the performance standards from a 90 percent compliance rate to a 95 percent compliance rate.**

In addition, the department is requesting an increase of \$195,000 (\$97,000 General Fund) to support two Associate Medi-Cal Eligibility Analysts to maintain oversight of this county performance measure system.

Background—Existing County Performance Measures for Medi-Cal Program.

Federal Medicaid (Medi-Cal) law requires states to use a governmental entity to make eligibility determinations. In California county social services departments are responsible for implementing Medi-Cal eligibility and for interpreting state guidance on policies and procedures. Counties determine eligibility for Medi-Cal under a set of complex rules that require staff to collect and verify a variety of information.

In 2003 the Legislature enacted comprehensive “county performance standards”. Under these standards, counties must meet specified criteria regarding completing Medi-Cal Program eligibility determinations and performing timely re-determinations. **A 90 percent threshold was specifically chosen to reflect the complexity of the Medi-Cal Program.**

Specific work standards—including timeframes and percentages that need to be completed—are outlined in the enabling statute. If a county does not meet these performance standards, their administrative funding may be reduced by up to 2 percent as determined by the Department of Health Care Services. Further, implementation of a corrective action plan in those counties that fail to meet one or more of the standards are required.

The county performance standards address the following *key* requirements:

- Medi-Cal **eligibility application** processing;
- Medi-Cal **annual redetermination** processing; and
- Bridging processing (used to shift children between Medi-Cal and Healthy Families as appropriate based on program eligibility standards).

As contained in the Medi-Cal Estimate for 2007-08, these ongoing county performance standards are estimated to save *at least* \$450 million (\$222.8 million General Fund).

Background—Medi-Cal Eligibility Determination System (MEDS) Reconciliation.

Additional standards were implemented in the Budget Act of 2003, and accompanying trailer bill language to ensure that counties were appropriately reconciling their Medi-Cal eligibility files with the state’s system. This included the establishment of standards regarding the processing of error “alerts”, as well as submitting quarterly reconciliation files to the DHS for data verification and correcting any subsequent identified errors. **If a county fails to follow these standards, the DHS will request a Corrective Action Plan from the county. If the county fails to meet the Corrective Action Plan’s benchmarks, the DHS may reduce the county administrative allocation for Medi-Cal**

by two percent.

Background—Medi-Cal Eligibility Processing is Complex. Each county is responsible for implementing Medi-Cal eligibility and for interpreting state guidance on policies and procedures. Counties determine eligibility for Medi-Cal under a set of complex rules that require staff to collect and verify a variety of information. **In fact the DHS provides counties with a 900-plus page state Medi-Cal Eligibility Procedures Manual that is updated on a constant basis through state issued “All County Letters”. There are more than 150 aid codes, and dozens of state Medi-Cal related forms.**

Counties are provided with an annual allocation from the state to conduct Medi-Cal Program eligibility processing activities for the state (federal law requires that a governmental entity complete all Medicaid (Medi-Cal) applications.) The allocation is contained within the annual Medi-Cal Estimate Package provided to the Legislature as part of the annual budget deliberations. The budget proposes expenditures of about \$1.4 billion (\$662.5 million General Fund) for county administration of the Medi-Cal Program.

Federal Deficit Reduction Act Adds Complexity to Medi-Cal Eligibility Processing. Among other things, the DRA made changes to the Medicaid Program (Medi-Cal) that deal with citizenship and identity documentation, asset eligibility, and disabled Supplemental Security Income (SSI). These requirements have placed additional administrative requirements on to counties for Medi-Cal eligibility processing.

The DRA changed eligibility requirements by requiring that any person who declares to be a citizen or national of the U.S. must now provide that documentation of citizenship and identity. People applying for Medi-Cal must provide that documentation before full scope Medi-Cal can be approved. If this documentation is not provided, Medi-Cal is limited to emergency and pregnancy related services. Enrollees that are now receiving Medi-Cal services who enrolled prior to the DRA changes must provide documentation at their next redetermination in order to receive full-scope continuing Medi-Cal services. **This citizenship documentation requirement will affect over 4 million individuals, or about 62 percent, enrolled in Medi-Cal.**

With respect to asset eligibility, the DRA requires individuals who are requesting long-term care services or Waiver services will have to undergo an additional asset eligibility determination for payment of those services. Although these individuals may be eligible for Medi-Cal services of all other covered services, they may not be eligible to receive Medi-Cal-funded long-term care and Waiver services.

The asset eligibility changes also applies to individuals requesting services who, in the past, have received Medi-Cal automatically based on an eligibility determination made by the Social Security Administration for SSI/SSP or by CalWORKS.

Constituency Concerns—County Welfare Directors Association. The Subcommittee is in receipt of a letter from the County Welfare Directors Association (CWDA), the state's partner in administering the Medi-Cal Program. The CWDA is requesting modifications to the Administration's proposal as follows:

- Modify the existing performance schedule to recognize the challenges associated with implementing the citizenship and identify documentation requirements of the federal Deficit Reduction Act (DRA).
- In lieu of increasing the performance percentage from 90 percent to 95 percent, increase the percentage to 92 percent beginning as of January 2009.
- Requiring the state to provide additional support to counties to identify best practices in eligibility determination and annual redetermination processing, and to update conflicting state rules and regulations.

A key aspect of the CWDA letter is that the Medi-Cal process overall—its administration and eligibility processing—need to be simplified. If the directions from the state were established in one set of comprehensive instructions for the counties to use, and if the Medi-Cal eligibility process was more streamlined (less forms, pre-populating the annual redetermination forms and other aspects), a higher performance standard could be achieved.

Subcommittee Staff Recommendation. First, it is recommended to **delete** the \$195,000 (\$97,000 General Fund) to fund two Associate Medi-Cal Eligibility Analysts. The DHCS received 4 positions to oversee county performance standards originally and has received additional positions to conduct on-site fiscal reviews of counties to verify the accuracy of Medi-Cal claimed costs (for eligibility processing). In addition, the DHCS has a comprehensive Medi-Cal Division (over 1,700 employees) which has core staff available to oversee the counties. Further, the DHCS has an Audits and Investigations Division that can also be used to oversee county functions when applicable.

Second, it is recommended to **hold open the trailer bill legislation** to see if a compromise can be obtained. Subcommittee staff concurs with the CWDA that a 95 percent level is unworkable at this time due to the need for the state to improve its own operations, as well as the need to implement the federal DRA requirements which will be quite difficult and should be focused on.

In addition, the state needs to be a better business partner. The state needs to undertake a review of the Medi-Cal Program manual, regulations and all-county letters. Counties, as well as advocacy groups, should have clear instructions about how the program operates and the requirements they need to fulfill. As such, trailer bill language regarding the states efforts to proceed with this should be part of any compromise language.

Questions. The Subcommittee has requested the Medi-Cal Program to respond to the following questions:

1. Medi-Cal, Please provide a brief summary of how the state monitors the county's administration of Medi-Cal eligibility processing and how the present monitoring standards are operating.
2. Medi-Cal Program, Please provide a brief summary of the budget proposal and the trailer bill language.

5. Administration's Trailer Bill Language-- AB 1629 Nursing Home Rates

Issue (See Hand Out). The Administration is proposing trailer bill legislation to modify Assembly Bill 1629 (Frommer), Statutes of 2004, which implemented a facility specific rate setting system for facilities providing long-term care services (nursing homes). **The Administration's language proposes *three key changes*.**

First, a reduction of \$28.8 million (\$14.4 million General Fund) is proposed by reducing the maximum annual rate increase or "growth cap" to 4.5 percent, instead of the presently required 5.5 percent as contained in statute. The proposed 4.5 percent would be effective as of January 1, 2008. The Administration contends this change is necessary due to recent federal law changes regarding "Quality Assurance Fees", as well as an overall need to reduce General Fund expenditures.

Second, it would provide that beginning with the 2008-09 rate year, the maximum annual increase in the weighted average Medi-Cal rate for nursing homes would be adjusted based on a "medical" consumer price index (language needs to be fixed), and not by other factors as presently contained in statute. This aspect of the proposal would reduce and flatten-out future rate increases for nursing homes.

Third, the Administration would extend the sunset date for this nursing home rate methodology by one year, from July 31, 2008 to July 31, 2009.

Background---Summary of Key Aspects of Assembly Bill 1629 (Frommer), Statutes of 2004. This legislation created a "*facility-specific*" Medi-Cal reimbursement methodology for nursing homes, and authorized a provider "*Quality Assurance Fee*" to assist in providing a Medi-Cal rate increase.

The purpose of these changes were to devise a rate-setting methodology that: (1) encouraged access to appropriate long-term care services; (2) enhanced quality of care; (3) provided appropriate wages and benefits for nursing home workers; (4) encouraged provider compliance with state and federal requirements; and (5) provided administrative efficiency.

The key components of the nursing home rate methodology contained in this enabling legislation are as follows:

- Establishes a **baseline reimbursement rate** (weighted average rate) *and* state maintenance of effort level (methodology in effect as of July, 2004 plus certain specified adjustments). (The facility-specific rate and "Quality Assurance Fee" rate increases are built upon this baseline.)
- Establishes a **"facility-specific" Medi-Cal reimbursement methodology** for nursing homes. Payment is based upon each facility's projected costs for five major cost categories: (1) labor costs; (2) indirect care non-labor costs; (3) administrative costs; (4) capitol costs—"fair rental value system"; and (5) direct pass-through costs (proportional share of actual costs, adjusted by audit findings).

- Imposed a **“Quality Assurance Fee”** on all nursing homes (about 1,200 facilities), not to exceed 6 percent, which is deposited in the state treasury and is used to fund the specified rate increases, as well is used to offset some General Fund expenditures (amounts vary each year for the rate increase and General Fund savings levels).
- Limits growth in the overall Medi-Cal reimbursement rate for nursing homes through the use of spending caps. These spending “caps” were agreed to because facility-specific reimbursement systems can be inflationary. The spending “caps” contained in the enabling legislation are:
 - ✓ 2005-06 8 percent (of the weighted average rate for 2004-05);
 - ✓ 2006-07 5 percent
 - ✓ 2007-08 5.5 percent (**note: Administration wants to reduce to 4.5 percent**)

Background—“Quality Assurance Fees” and the Federal Changes. California presently uses a “Quality Assurance Fee” for the “AB 1629” nursing home rate methodology, as well as within the Medi-Cal Managed Care Program. These fees are collected from providers on a quarterly basis and are used by the state to obtain additional federal funds to provide rate increases for these two areas. In addition, net General Fund revenues (savings) are obtained from these actions.

Generally, within specified requirements, federal Medicaid law allows states to collect fees from providers for expenditure in the Medicaid Program (Medi-Cal Program in California). Several states use these “Quality Assurance Fees” to support their programs.

Effective January 2008, the federal government is lowering the 6 percent threshold for fees to 5.5 percent. According to the DHCS, this change will not affect the state’s General Fund support in 2007-08, but will result in a loss of about \$12 million General Fund in 2008-09. (The amount of Quality Assurance Fee collected by the state and going into the state treasury will be reduced. A portion of the Quality Assurance Fee is used to fund Medi-Cal reimbursement rates and a portion is used to offset General Fund expenditures overall.) **The Administration’s proposed trailer bill language would conform state statute to this upcoming federal change.**

From a technical perspective, the state’s threshold percentage is calculated based on “non-Medicare” revenues but does not presently capture expenditures facilities have to pay related to licensing and certification fees. The federal government’s threshold percentage is calculated base on revenues, including Medicare and is supposed to include licensing and certification expenditures. **The bottom line here is that the state needs to clarify the exact dollar amount to be captured under the state’s threshold percentage. They will be clarifying this aspect with the industry shortly.**

Background—Bureau of State Audits Report—February 2007 Report. In a recent audit, the Bureau raised the following concerns regarding the DHCS administration of the AB 1629 process. Key concerns included the following:

- DHCS has not appropriately documented the methodology underlying the reimbursement rate system as designed by Navigator (contractor used to calculate the

AB 1629 rate system). The DHCS needs to document this process as well as any future rate changes made.

- DHCS, through the fiscal intermediary claims billing system, inadvertently authorized duplicate payments of \$3 million for some facilities. The DHCS needs to formalize a rate change process that documents the reason for a rate change and provides a notification of the rate change to the fiscal intermediary (Electronic Data Systems).
- DHCS has not yet been able to collect all of the Quality Assurance Fees owed to the state.

Generally, the DHCS concurred with the audit findings and in the process of making changes. **They intend to provide a 60-day response to this audit report to the Bureau which will document the rate development system and address other issues.** This report should be forthcoming within a week or so.

Background—Table of Expenditures Comparing Prior System to New System. The Medi-Cal Program has prepared a chart to display the benefit of the AB 1629 rate method, as compared to the prior rate method, for both the state and constituency groups. As noted below, the AB 1629 rate method, because of the use of the Quality Assurance Fees, has enabled the state to save resources and for more overall funding to be placed into the nursing home system.

Summary Table Displaying the Benefit of the AB 1629 Rate Method (*Dollars in thousands*)

I. Prior System	2005-06	2006-07	2007-08
Reimbursements to Nursing Homes	\$3,038,026	\$3,144,357	\$3,254,410
Federal Cost	\$1,519,013	\$1,572,178	\$1,627,205
State General Fund Cost	\$1,519,013	\$1,572,178	\$1,627,205
Net Cost to State	\$1,519,013	\$1,572,178	\$1,627,205
II. AB 1629 Rate System			
Reimbursements to Nursing Homes	\$3,343,374	\$3,510,543	\$3,703,622
Federal Cost	\$1,671,687	\$1,755,271	\$1,851,811
State General Fund Cost	\$1,671,687	\$1,755,271	\$1,851,811
Quality Assurance Fee (offsets GF) (100% collection rate)	\$233,150	\$244,807	\$258,272
Net Cost to State	\$1,438,537	\$1,510,464	\$1,593,540
General Fund Savings (comparison)	\$80.5 million	\$61.7 million	\$33.7 million

Constituency Concerns with Governor's Proposal. The Subcommittee is in receipt of letters from industry organizations, labor organizations and others expressing considerable concern with the Administration's proposal. The key concern is the reduction to the reimbursement rate (by lowering the spending cap to reduce the percentage of rate increase).

Organizations state that this reduction undermines the basis for the "Quality Assurance Fee". They contend that the industry and labor have been assuming a certain level of rate adjustment for the upcoming year based upon the existing statute. As such, the proposed reduction would be problematic.

Subcommittee Staff Recommendation—Hold Open. It is recommended to hold this issue open pending the May Revision for discussions with the Administration and constituency groups to continue and to obtain an update on the state’s revenue situation.

Questions. The Subcommittee has requested the Department of Health Care Services to respond to the following questions.

1. Medi-Cal, Please provide a brief summary of how the existing “AB 1629” nursing home reimbursement rate works, and how it would change under the budget proposal including both the reduction to 4.5 percent *and* the medical consumer price change.
2. Medi-Cal, Please clarify why the Administration wants to extend the sunset date for only one-year (from June 30, 2008 to June 30, 2009).

C. ISSUES FOR DISCUSSION—Licensing & Certification Division

1. Administration Proposes Substantial Fee Increases

Issue. The Administration is proposing to substantially increase the fees paid by health care providers to be licensed and certified by the Department of Public Health. **These proposed fee increases are attributable to several factors, including the following:**

- The Administration proposes to eliminate \$7.2 million General Fund from the program and shift these expenditures to the L&C Fund, and thereby increase fees accordingly.
- The Administration's budget change proposals, including increases for administrative support and chaptered legislation, equate to an increase of \$11.5 million in L&C Fund expenditures if they are adopted without modification.
- The Administration's baseline adjustments for labor and personnel, such as employee compensation and retirement, as well as operating expenses equate to an increase of \$3.7 million (L&C Fund).
- The Administration's pro rata adjustment for the L&C Division equates to an increase of \$4.2 million (L&C Fund). (This is a technical adjustment that reflects the Divisions share of the Department of Public Health's portion of funding for pro rata.)

By deleting the General Fund support, and by adding in additional expenditures onto the base L&C Program as referenced above, the L&C Division then applies calculations as contained in Section 1266 of Health & Safety Code to determine the individual health care facility fees. The table below reflects the Administration's proposed L&C fee schedule.

Administration's Proposed Fee Schedule (Also see Hand Out re: Frequency of L&C Survey)

Facility Type	Fee Category	2006-07 Fee (Budget Act 2006)	Administration's 2007-08 Fee	Difference (+/-)
Referral Agencies	per facility	\$5,537.71	\$6,798.11	\$1,260.40
Adult Day Health Centers	per facility	4,650.02	4,390.30	-259.72
Home Health Agencies	per facility	2,700.00	5,568.93	2,868.93
Community-Based Clinics	per facility	600.00	3,524.27	2,924.27
Psychology Clinic	per facility	600.00	3,524.27	2,924.27
Rehabilitation Clinic (for profit)	per facility	2,974.43	3,524.27	549.84
Rehabilitation Clinic (non-profit)	per facility	500.00	3,524.27	3,024.27
Surgical Clinic	per facility	1,500.00	3,524.27	2,024.27
Chronic Dialysis Clinic	per facility	1,500.00	3,524.27	2,024.27
Pediatric Day Health/Respite	per bed	142.43	139.04	-3.39
Alternative Birthing Centers	per facility	2,437.86	1,713.00	-724.86
Hospice	per facility	1,000.00	2,517.39	1,517.39
Acute Care Hospitals	per bed	134.10	309.68	175.58
Acute Psychiatric Hospitals	per bed	134.10	309.68	175.58
Special Hospitals	per bed	134.10	309.68	175.58
Chemical Dependency Recovery	per bed	123.52	200.62	77.1
Congregate Living Facility	per bed	202.96	254.25	51.29
Skilled Nursing	per bed	202.96	254.25	51.29
Intermediate Care Facility (ICF)	per bed	202.96	254.25	51.29
ICF-Developmentally Disabled	per bed	592.29	701.99	109.70
ICF—DD Habilitative, DD Nursing		1,000 per facility	701.99 per bed	3,211.94 per facility
Correctional Treatment Centers	per bed	590.39	807.85	217.46

As required by statute, the Administration published a list of the above *estimated* fees on February 1, 2007 and has provided additional background to several constituency groups regarding how the fees are calculated. However, since this is the first year for implementation of a new methodology, several organizations are not clear on how their particular health care category of fees was fully determined.

With respect to the cost factors identified above (a through d), the following comments are offered. The Administration's proposed elimination of General Fund support and shifting to fees is contrary to the agreement crafted through the Budget Act of 2006. The Administration has made a policy choice by accelerating the phase-in of the fee schedule, as discussed more below. The adjustment for employee compensation is reasonable since it pertains to the cost of doing business.

The Administration's proposed \$4.2 million pro rata adjustment is a new expenditure for which the L&C Division will need to incur due to Department of Finance requirements. In essence, a pro rata adjustment is the recovery from special funds of costs incurred by central service agencies (such as Department of Personnel Administration, Department of Finance and the State Controller's Office).

Background—Budget Act of 2006 & General Fund Support Provided. Through the Budget Act of 2006, a total of 155 positions, including 96 Health Facility Evaluator Nurse (HFEN) positions, 16 HEFN Supervisors, and 8 Pharmacy Consultants were provided.

A key aspect of this agreement last year was the acknowledgement that the L&C Division was woefully understaffed and not meeting standards for ensuring patient safety and medical quality, including not responding to complaints at nursing homes on a timely basis. As such, these positions were added to commence with numerous improvements.

Another key aspect of this agreement was that a revised fee system, along with the establishment of a special fund to capture the fees, would be phased-in over a three year period (i.e., would become fully fee supported by no later than 2009-2010). **The revised fee system has many complexities, including the implementation of a more comprehensive timekeeping system to more appropriately track HFEN surveyor work and "billable" time, as well as identifying an overall appropriate *program base* from which to build.**

As noted in extensive discussions in Subcommittee last year, the L&C Division sustained a reduction of 166 positions over a period of several years due to unallocated General Fund reductions on state support. Specifically, vacant positions were swept and counted as General Fund savings since the program had not yet established a special fund. These actions were as follows:

- 2000-2001 (vacancy reduction) 21 positions were reduced of which 20 were Health Facilities Evaluation Nurses.
- 2001-02 (unallocated reduction) 15 positions were reduced and all of them were Health Facilities Evaluation Nurses.

- 2002-03 (vacancy reduction) 39 positions were reduced and all were professional classifications (HFENs, analysts and pharmacy-related), except for 11 that provide clerical and data support.
- 2003-04 (unallocated reduction) 91 positions were reduced of which 32 were nursing classifications, 15 were other professional classifications (analysts, information specialists, and legal) and 44 that provide clerical and data support.

Therefore in many ways, the additional 155 positions provided in the Budget Act of 2006 was an effort to restore the L&C Division to a base program level.

Background—Need to Fill Vacant Positions. The L&C Division has historically had difficulty filling positions, some of which is due to a persistent nursing shortage.

The L&C has taken several steps to recruit nurses to fill vacancies, including the use of new proactive recruitment strategies. In addition, they have shortened the length of time it takes to get a newly hired nurse trained and tested from 18 to 24 months to 12 to 18 months. However, as noted by the LAO and a recently released Bureau of State Audits Report (April 12, 2007), L&C is still having difficulty in filling vacancies.

The Bureau of State Audits has recommended for the L&C Division to work with the Department of Personnel Administration (DPA) regarding employee compensation. In response, the DHCS stated their intent to submit a comprehensive plan to the DPA regarding the hiring and retention of qualified individuals to perform surveys and complaint investigations.

Background—Need to Improve Overall L&C Division Consistency and Efficiencies. Various health care facilities have raised issues over the past several years regarding interpretations made of licensing and certification policies and procedures at L&C Field Offices. There have been variances across the state as to how certain policies are to be implemented, as well as to what paperwork is required for processing certain documents, including the certification process (which enables a provider to obtain Medi-Cal reimbursement). **Further, various inefficiencies have been identified by health care facilities who are seeking an “efficient service” for which they pay a fee.**

The L&C Division states they are *beginning* to address some of these multi-layered issues, and have provided some examples as follows:

- Centralized the application process for nursing homes and ICF-DD facilities to ensure standardized processing. Work still needs to be done to centralize the application processing for Home Health Agencies.
- Application forms for nursing homes, ICF-DD facilities, community clinics and Home Health Agencies can now be uploaded from the DHCS Licensing and Certification Division web page.
- The documentation and write-up phases of complaint investigations have been streamlined and they content this new protocol has been tested to ensure that there has been no diminution of complaint findings.
- L&C Division will soon be meeting with Community Clinic providers to conduct a joint training in August. L&C has revised their website to list forms that need to be submitted by Community Clinic applicants when applying for a new license, certification or “Change or Ownership” (CHOW).

- L&C Division will be crafting a “District Office Memorandum” with policies and procedures related to Community Clinic provider licensing and affiliate clinic licensing surveys. These policies and procedures are presently being discussed with constituency groups.

Overall Background—Purpose of Licensing & Certification. The DHCS L&C Division conducts licensing and certification inspections (surveys) in facilities to ensure their compliance with minimum federal certification and state licensing requirements in order to protect patient health and safety.

L&C is also responsible for investigating complaints from consumers, consumer representatives, the Ombudsmen, and anonymous sources, against health facilities. L&C is a statutorily mandated enforcement agency.

Certification is a federal prerequisite for health facilities and individual providers wanting to participate in and receive reimbursement from both Medicare and Medicaid (Medi-Cal). The DHS is the designated entity under contract with the federal CMS to verify that health facilities meet minimum certification standards. Federal grant funds are allocated to California to conduct work associated with Medicare. In addition, L&C fees are collected from the various facilities and are placed into the L&C Fund. General Fund support is also provided for some facilities to support L&C functions.

There are over 7,000 public and private health care facilities throughout the state, including hospitals, nursing homes, clinics and home health agencies.

Constituency Concerns Continue. Though progress has been made in several areas, the Subcommittee is in receipt of letters expressing substantial concerns regarding the substantial fee increases, the elimination of the \$7.2 million General Fund support provided in 2006-07, and the overall perceived lack of “service” for the various fees that is being paid (or proposed to pay). Examples of concerns with service include the following:

- Continued difficulties for Community Clinic providers to obtain licensure and certification of affiliate clinics (existing statute provides for a streamlined process).
- Continued and on-going backlogs for licensing and certification (in order to receive Medicare and Medi-Cal reimbursement) approvals. There is a considerable backlog for Home Health Agencies in particular.
- L&C staff who are not well trained and have an inconsistent understanding of licensing and certification requirements.
- Lack of clarity as to how L&C surveyor workload hours are attributed to the various healthcare facilities for the determination of fees to be paid. Several organizations are concerned because the workload hours L&C is using for fee determinations may not be accurate they believe.

Subcommittee Staff Recommendation. The L&C division is making considerable progress, but it is acknowledged that considerably more work needs to be accomplished. Vacant positions need to be filled, more streamlining needs to be put into action, and coordination and consistency across the L&C Field Offices is needed.

Many of these issues are documented and discussed at length within the Bureau of State Audits Report, "It's Licensing and Certification Division is Struggling to Meet State and Federal Oversight Requirements for Skilled Nursing Facilities", released on April 12, 2007.

As such, it is still very much another transition year. Therefore, to have the program fully fee supported places an undue burden on many health care providers. In addition, it was the intent of the Legislature last year to have a phased-in approach to the fees. Therefore, it is recommended to place \$7.2 million (General Fund) on the Subcommittee's priority list to fund.

Further, it is recommended for the L&C Division to report back to the Subcommittee on May 7th as to what additional streamlining actions they have taken to meet constituency needs and those that could be taken in the near future.

Questions. The Subcommittee has requested the Administration to respond to the following questions.

1. L&C Division, Please provide a brief update as to key changes that have been recently implemented.
2. L&C Division, Where is the Administration in providing the Department of Personnel Administration with a plan regarding recruitment and retention, and employee compensation?
3. L&C Division, Please provide a brief description of how the Administration's L&C Fee schedule was determined. Why did the Administration delete the \$7.2 million in General Fund support?

2. Implementation of Senate Bill 1312 (Alquist), Statutes of 2006 & Trailer

Issue. The Administration is requesting **an increase of \$2.5 million** (Licensing and Certification Fund) to support 16 positions, and augment a contract the state has with Los Angeles County, to implement the provisions of Senate Bill 1312 (Alquist), Statutes of 2006. In addition, the Administration is proposing trailer bill language (April 12, 2007 version) to clarify certain aspects of the enabling legislation.

Senate Bill 1312 (Alquist), Statutes of 2006, requires the Licensing and Certification (L&C) Division of the Department of Public Health to do the following:

- Identify all state law standards for the staffing and operation of long-term health care facilities;
- Reinstate periodic licensing surveys for all long-term health care facilities; and
- Authorize the imposition of administrative penalties for incidents occurring at facilities on or after January 1, 2007.

Prior to SB 1312, the state was no longer conducting state surveys in certified facilities where federal surveys were conducted. However, under SB 1312, regardless of the federal survey results, a state licensure survey is required. L&C Division surveyors may review the outcomes of the federal surveys to identify areas where problems were previously identified in a facility; however, the facility would still need to meet the state standards.

First, a total of 16 positions are requested for the Licensing and Certification (L&C) Division at a cost of \$1.9 million. The L&C Division assumes that they would conduct a joint federal *and* state survey and inspect facilities' compliance with state standards "to the extent that those standards provide greater protection to residents, or are more precise than federal standards." **Specifically, the L&C Division would inspect for any differences between the state and federal requirements and they estimate this would add 20 hours to the federal survey. This standard equates to 13 permanent L&C Division field positions** (i.e., 10 Health Facility Evaluator Nurses, 1.5 Health Facility Evaluator Nurses—Supervisor, and 1.5 Program Technicians).

An additional Health Facility Evaluator Specialist is requested to identify state standards for the staffing and operation of long-term care facilities and to begin using those standards for the reinstated licensing inspections.

The remaining two positions are for legal services. These include 1.5 Staff Counsel positions and 0.5 Administrative Law Judge. These positions are requested to implement the administrative penalties and handle legal issues that arise from conducting these additional surveys.

Second, as previously noted, the state contracts with Los Angeles County to conduct licensing and certification work in that region. As such, an increase of \$559,000 (Licensing and Certification Fund) is necessary for the county to meet the requirements of the enabling legislation.

Third, the Administration is proposing trailer bill language to clarify a few aspects of the enabling legislation. **First**, it clarifies that the L&C Division will inspect for compliance with provisions of state law and regulations during a state periodic inspection *or* at the same time as a federal periodic inspection. **Second**, it clarifies that the cost of the additional inspections and surveys may be recovered by an increase in initial license and renewal fees for long-term care facilities. **Third**, it clarifies the administrative penalties to be imposed on hospitals. This clarification was needed due to an overlap with other chaptered legislation (i.e., AB 774, Statutes of 2006).

Subcommittee Staff Recommendation--Approve. It is recommended to adopt the April 12, 2007 version of the trailer bill language, as contained in the hand out, and to approve the budget request for the positions.

Questions. The Subcommittee has requested the L&C Division of the Department of Public Health to respond to the following questions.

1. L&C Division, Please explain how the state surveys are to be conducted.
2. L&C Division, Please provide a brief summary of the budget request.
3. L&C Division, Are there any concerns with any of the implementation aspects regarding SB 1312? If so, please explain.

3. Senate Bill 1301 (Alquist)—Hospital Inspections & Reporting (DPH)

Issue. The Administration is proposing a **total increase of \$7.4 million** (Licensing and Certification Fund) to implement Senate Bill 1301 (Alquist), Statutes of 2006, *and* to develop the internet-based information system required by Assembly Bill 893 (Alquist), Statutes of 1999, and modified by Senate Bill 1301.

This request includes the following: **(1)** \$5.6 million for 45 state positions; **(2)** \$1.2 million to augment the Los Angeles County contract; and **(3)** \$569,000 in additional funds for reporting requirements related to the Licensing and Certification website.

Senate Bill 1301 (Alquist), Statutes of 2006, amended existing statute to **(1)** establish a system for the timely reporting of medical errors in hospitals; **(2)** increase the frequency of licensing inspections of hospitals that report serious medical errors; **(3)** report these errors to the public; and **(4)** require the Department of Public Health's Licensing and Certification (L&C) Division to track and report this information.

In order to meet these requirements, the Administration is requesting additional resources. Each of the three fiscal components is discussed below.

- **(1) Licensing and Certification (L&C) Division Staff (Total Increase of \$5.6 million for 45 staff).** The Licensing & Certification Division is requesting a total of 45 positions to complete the work associated with implementing this legislation. These positions are needed in four areas— inspections, regulations, information technology development, and support functions. **Each of these areas is discussed below.**

(A) L&C Division Inspection Staff (42 Positions). The Administration states that hospital reporting of adverse events will dramatically increase time spent inspecting hospitals. Additional staff is requested to conduct the additional on-site inspections, follow-up, and annual inspections of adverse events as required by the legislation.

Specifically, the following positions are requested for the inspection team:

- 1 Health Facilities Evaluator II--Supervisor
- 21 Health Facilities Evaluator Nurses;
- 5 Medical Consultants;
- 5 Pharmacy Consultants;
- 1 Public Health Nutrition Consultant;
- 5 Medical Records Consultants; and
- 4 Program Technician II's

With respect to the Health Facilities Evaluator Nurses, the L&C Division states that the 21 positions are based on the fact that it takes 14 hours to conduct a reported incident investigation, and it takes an additional 14 hours to conduct on-site follow-up visits when adverse events are reported. There were 1,050 reported incidents in 287 hospitals last year. Therefore 1,050 incidents multiplied by 28 total hours equates to 21 positions (assuming 1,364 hours annually per position).

(B) L&C Division Regulation Staff (One Staff). The L&C Division is requesting an Associate Governmental Program Analyst position to develop regulations to clarify the language in the legislation regarding such terms as “adverse events”.

(C) L&C Division Information & Technology (Four Staff). The L&C Division is requesting one Senior Information Systems Analyst, one Staff Programmer Analyst, and two Associate Information System Analysts to design and implement the database necessary to track and report adverse events at hospitals as required by the legislation. These positions would also provide (1) system training to the new inspection surveyors to capture the survey findings and issue civil money penalty citations, and (2) on-going system maintenance support.

(D). Administration Division (2 Staff). The Administration Division within the Department of Public Health is requesting support for personnel and accounting functions. Specifically they are requesting (1) a 0.5 Personnel Analyst; (2) a 0.5 Personnel Specialist; (3) a 0.5 Accountant, and (4) a 0.5 Accounting Technician. They contend these positions are needed for recruitment, hiring and retention, as well as for processing travel claims and related accounting functions associated with the additional L&C Division inspection staff.

- **(2) Los Angeles County Contract (Increase by \$1.2 million).** The state contracts with Los Angeles County to conduct certification surveys within the county. As such, an increase in the contract of \$1.2 million (Licensing and Certification Fees) is proposed to hire staff to meet the requirements. The methodology used to calculate this adjustment is consistent with past practices.
- **(3) L & C Website (Increase of \$569,000).** According to the Administration, the total project cost is \$1.6 million for 2007-08, including the four information systems positions above. The Feasibility Study Report for the project was approved as of March 14, 2007 by the DOF. The \$1.6 total project cost consists of \$1.2 million in one-time expenditure for software, hardware and project management. The ongoing costs total \$390,000. The propose increase is primarily for certain software customization.

The L&C Division states that this website will meet the requirements contained in Assembly Bill 893 (Alquist), Statutes of 1999, as well as those contained in Senate Bill 1301 (Alquist), Statutes of 2006. The Administration has revised its timeline to have the long-term care facilities component of the website operational by December 2007.

Overall Background—Senate Bill 1301 (Alquist, Statutes of 2006). SB 1301 increases governmental oversight and promotes disclosure of errors directly to the affected patient and to the public. Specifically, it requires that hospitals (General Acute Care, Acute Psychiatric and Special Hospitals) report 27 adverse events for which they were not previously required. It defines the adverse events, reporting requirements, and consequences of not reporting. Hospitals must begin reporting adverse events on July 1, 2007, and the L&C Division must make this information available to the public.

The law also requires the L&C Division to make an on-site inspection within 48 hours of receipt of a written or oral complaint that indicates an ongoing threat of imminent danger of bodily harm or death.

Background on the Internet-Based Information and Reporting. Assembly Bill 893 (Alquist), Statutes of 1999, requires the Department of Public Health's Licensing and Certification (L&C) Division to establish and develop an internet based consumer information system to provide updated information to the public and consumers regarding long-term care facilities. Though the legislation contained an operational date of July 1, 2002, it has yet to be implemented.

The consumer information service system is to include, at a minimum, all of the following elements:

- An on-line inquiry system accessible through a statewide toll-free number and the internet;
- Long-term care health facility profiles, with data on services provided, a history of all citations and complaints for the last two full survey cycles, and ownership information. This profile is to include a description of the facilities services, information regarding substantiated complaints and state citations, and any special resolution pertaining to a citation; and
- Where feasible, the department is to interface the consumer information service system with its "automated certification and licensure information management system".

Senate Bill 1301 (Alquist), Statutes of 2006, added hospitals, including general acute care hospitals, acute psychiatric hospitals and special hospitals, to this overall requirement.

Subcommittee Staff Recommendation—Approve and Adjust Budget Bill Language. It is recommended to approve the budget proposal and to technically adjust Budget Bill Language to reflect the updated Finance Letter expenditures.

Questions. The Subcommittee has requested the L&C Division to respond to the following questions.

1. L&C, Please provide a brief description of the entire request, including the need for the positions.
2. L&C, Please discuss the timeline for the implementation of the website.

4. Nursing Home Administrator Program

Issue. The budget proposes a net increase of \$57,000 (Nursing Home Administrator's State License Examining Fund), along with a redirection of \$110,000 (from operating expenses within the program) to fund a Staff Services Manager I and 1.5 Associate Governmental Program Analysts to investigate complaints and citations received by the Nursing Home Administrator Program and to ensure that statutory and regulatory duties are met.

The department states that the Nursing Home Administrator's Program is currently understaffed and unable to meet the mandates of state law. Presently there is 2.5 staff working within the program at the L&C Division. When the program was operated by the Department of Consumer Affairs, five staff was utilized. **Among other things, the L&C Division states that the program has been *unable* to do the following due to a shortage of staff:**

- Promptly investigate complaints and citations. There is currently a backlog of about 83 complaints and over 800 citations. This number continues to increase each month.
- Review and update procedures to ensure that individuals licensed as nursing home administrators will, during any period that they serve as an administrator, comply with the required standards.
- Maintain the relevancy and currency of the state nursing home administrator exam.
- Provide paper-based and onsite monitoring of the Administrators-in-Training Program to ensure that people are being appropriately trained.
- Randomly audit certification forms and certificates provided by Nursing Home Administrators as proof of completion of continuing education courses for license renewal to substantiate completion of said courses.

The proposed 2.5 positions would primarily be used to: **(1)** conduct investigations and enforcement activities; **(2)** ensure that nursing home administrator's applicants meet required standards for licensure; ensure the timely approval of continuing education providers and courses; and **(3)** maintain the relevancy of the state licensing examination.

The department believes that 40 complaint cases per year can be investigated and that the current backlog will be eliminated in about two years. Further, they intend to have the program develop, monitor evaluate and update as necessary an annual work plan for accomplishing the mandates set forth in the Nursing Home Administrator's Act (Assembly Bill 1409, Statutes of 2001). This annual plan is to identify goals and objectives, required activities, resources needed, timeframes, and expected outcomes that will result in the accomplishment of the defined mandates.

Background—Nursing Home Administrator Program. The purpose of this program is to protect the health and safety of the public by ensuring that only qualified persons are licensed and appropriate standards of competency are established and enforced.

Among other things, the Nursing Home Administrator's Act (Act) specifies licensing requirements for administrators, including the applications, examination, qualifications and continuing education requirements. The Act also addresses fees for state and national examinations and provides procedures for out-of-state Nursing Home Administrators licensees to obtain a one-year provisional license. In addition, the Act establishes a designated citation and administrative fine assessment system, streamlines enforcement functions and requires the Nursing Home Administrators Program to develop a specified administrator-in-training (AIT) program.

Besides investigating self-reported incidents, the Nursing Home Administrators Program is required to routinely review the citation logs and files of the Nursing Home Administrators whose facilities have received citations from the Licensing and Certification Division to determine if remedial or disciplinary actions against the administrator is warranted based on the administrator's involvement or culpability in the citations.

Subcommittee Staff Recommendation—Approve with Budget Bill Language. It is recommended to approve the budget request and to adopt Budget Bill Language as follows:

For Item 4265-001-0001:

"The Department of Public Health shall provide the fiscal and policy committees of the Legislature, by no later than January 15, 2008, a copy of the annual work plan for accomplishing the mandates set forth in the Nursing Home Administrator's Act. This work plan will identify goals and objectives, required activities, resources needed, timeframes, and expected outcomes that will result in the accomplishment of the defined mandates."

Questions. The Subcommittee has requested the L&C Division to respond to the following question.

1. L&C Division, Please provide a brief summary of the budget request.

5. Temporary Manager/Receiverships for Long-Term Care Facilities

Issue—Finance Letter. The Subcommittee is in receipt of a Finance Letter requesting a one-time only increase of \$1.9 million (\$1.4 million state Health Facility Citation Penalty Account and \$466,000 federal Health Facility Citation Penalty Account) to fund temporary manager/receiverships for long-term care facilities. With this increase, the total amount to be appropriated for this purpose in 2007-08 is \$5 million (both accounts).

The department states that the \$1.9 million increase is a one-time only adjustment while they gather sufficient expenditure and revenue data to determine a more permanent and workable funding mechanism for temporary manager/receiverships. This is because the funds would become insolvent in future years based on this continued expenditure level.

The department states that the overall 2007-08 cost estimate is based on the availability of facility cash resources for ongoing operational costs, the number of beds in the facilities, whether the facilities are federally certified to receive Medi-Cal funding to offset operational costs, and whether the receivership will require the relocation of residents.

It should be noted that temporary manager/receiver expenditures have been increasing as noted in the chart below. Further, the department notes that these two citation funds (state and federal) cannot maintain expenditure levels after 2007-08. **Therefore, the department will need to analyze, identify, and propose an alternative funding source for the temporary managers/receiverships for future fiscal years.**

Table: Department's Data on Cost of Temporary Managers/Receiverships

Fiscal Year	Amount Expended
2004-2005	\$2.3 million
2005-2006	\$6.5 million
2006-2007 (estimated)	\$8.9 million
2007-2008 (proposed but could be higher)	\$5.0 million

Background—Temporary Manager/Receiverships. The L&C Division is the entity responsible for overseeing the quality of health care provided in health facilities statewide and the appointment of Temporary Managers. The L&C Division must fund Temporary Managers and Receiverships and maintain facility operations to protect the health and safety of residents of long-term care facilities.

State statute requires the department to take action to protect the health and safety of residents of long-term care facilities. It authorizes the Director of the Department of Public Health to appoint a Temporary Manager when the following conditions exist:

- The residents of the long-term care facility are in immediate danger of permanent injury or death by virtue of the failure of the facility to comply with federal or state requirements applicable to the operation of the facility; and
- When the facility fails to comply with state law related to reducing transfer trauma of residents that are to be transferred due to the change in status of a facility's license or operations.

In addition, the Director may petition the Superior Court in the county in which the long-term care facility is located for an order appointing a receiver to temporarily operate the long-term care facility where certain circumstances exist, as contained in statute.

Background—Source of Funding. Funding for this program is comprised of moneys collected as a result of citation penalties levied against long-term care facilities and deposited into the Health Facilities Citation Penalties Account (state citation fund) and the Federal Citation Penalties Account (federal citation account).

Both of these funds provide immediate access to financial resources in emergency situations threatening the health and well being of residents in long-term care facilities.

The state citation fund consists of moneys collected as a result of state citation civil penalties levied against long-term care facilities. These funds can be used for many purposes including for long-term care resident relocation expenses; maintenance of facility operation pending corrections or closure (such as temporary management); reimbursing residents for personal funds lost; and the costs associated with informational meetings.

The federal citation fund consists of receipts for federal civil money penalties for federal survey deficiencies collected by the federal Centers for Medicare and Medicaid Services (CMS) and remitted to the state.

Bureau of State Audits Report (April 12, 2007). The BSA recommends for the L&C Division to take steps to gain assurance from temporary management companies that the funds they request and receive are necessary. Documentation for expenditures needs to be obtained. In addition, they should expand the pool of qualified temporary management companies to ensure that they have sufficient numbers of temporary management available and receive competitive prices.

Subcommittee Staff Recommendation. It is recommended to approve the budget request, along with the following Budget Bill Language:

For Item 4265-001-0001:

“By no later than November 1, 2007, the Department of Public Health shall provide the fiscal and policy committees of the Legislature with an action plan to address issues related to fiscal accountability and the selection process for temporary management appointments as identified in the Bureau of State Audits Report (2006-106).”

Questions. The Subcommittee has requested the L&C Division to respond to the following questions.

1. L&C Division, Please provide a brief overview of the Temporary Manager/Receiver process and how the budget request is to address the needs identified.
2. L&C Division, What is on the horizon for addressing the issues identified in the Bureau of State Audits Report regarding this area?

6. Health Care Associated Infections-Senate Bill 739 (Speier), Statutes of 2006

Issue. An increase of \$2 million (\$1.562 million General Fund and \$431,000 Licensing and Certification Fund) is proposed to support 14 positions and various contracts to implement Senate Bill 739, Statutes of 2006, which requires the establishment of a Healthcare Associated Infection Program.

The DHS states that two positions are presently used to address infection control issues, including a Public Health Medical Officer III located within the Division of Communicable Disease, and a Nurse Consultant located within the Licensing and Certification Program.

Specifically, the Department of Public Health (DPH) is proposing to hire a total of 14 positions which would be utilized in two divisions of the DPH as follows:

A. Division of Communicable Disease Control. Overall, this division will focus on the following core aspects: (1) development and analysis of reporting methods for healthcare facilities; (2) outbreak investigations and consultations; (3) development of guidelines for institutional infection control; (4) epidemiology and surveillance functions; and (5) laboratory support. These functions will specifically be conducted by the Infectious Disease Branch and the Microbial Diseases Laboratory Branch. **All of the 11 positions in the Division of Communicable Disease Control would be funded with General Fund support.**

✓ **Infectious Disease Branch—Total of 6 Positions.** An increase of six positions is requested including: two Public Health Medical Officer III's; a Nurse Consultant III (Specialist); two Research Scientist III (Epidemiology Biostatistics); and a Health Program Specialist I. These positions would be used to conduct the following key functions:

- Plan, organize and coordinate the surveillance activities of the program, including the development of state guidelines to control and prevent hospital infections.
- Review and develop hospital infection policies.
- Coordinate implementation of policies with healthcare facilities and local health jurisdictions.
- Provide consultation to various entities to control healthcare facility infections.
- Direct analyses of surveillance data on health care and community infections statewide and identifies areas of greatest need to direct special attention and resource allocation.
- Conduct data analyses and prepare analytic reports.
- Monitor contracts.

✓ **Microbial Diseases Laboratory--Total of 5 Positions.** An increase of 5 positions is requested, including a Research Scientist III, Research Scientist II, two Public Health Microbiologist II's, and a Public Health Laboratory Technician. These positions would be used to conduct the following key functions:

- Assist in the investigation and follow-up of clusters and outbreaks of health care facility associated infections.

- Provide sufficient laboratory efforts to support health care facilities and local health jurisdictions with pathogen identification, molecular epidemiology and anti-microbial susceptibility testing for the investigation of outbreaks.
- Oversee the development and evaluation of new tests and testing technologies for rapid detection and strain typing of hospital care associated infections.
- Perform scientific research studies of moderate scope and complexity for the detection of hospital care associated infections.

B. Division of Licensing and Certification—Total of 3 Positions. An increase of three positions, including two Nurse Consultant III's and a Research Scientist II (Epidemiology/Biostatistics) are requested. **These positions would be funded using special fee revenues deposited into the Licensing and Certification Fund.** These positions would be used to conduct the following core functions:

- Serve as the program's principal infection control resources for enforcement activities, regulations interpretation and development, and staff training and development.
- Review, interpret and revise the California Code of Regulations related to infection control.
- Prepare and present instructional materials and conduct ongoing training related to infection surveillance, prevention and control for internal training of surveyors.
- Conduct statistical analyses of and provide reports on licensing and certification data on healthcare associated infections and infection control.

The \$214,000 (total funds) in contract funds assumes consist of the following: (1) \$30,000 is used for the Health Care Infection Advisory Committee; (2) \$20,000 is for laboratory services; (3) \$64,000 is for a contract position in Los Angeles (for licensing and certification purposes); and (4) \$100,000 for reporting systems (as yet undetermined).

Background—Senate Bill 739, Statutes of 2006. This legislation requires the Department of Public Health (DPH) to: (1) implement a healthcare associated infection surveillance and prevention program; (2) investigate the development of electronic reporting, adopt new administrative regulations; and (3) evaluate the compliance of facilities with policies and procedures to prevent healthcare associated infections.

Core aspects of this enabling legislation are as follows:

- By July 1, 2007, the department shall require that each hospital, in accordance with Centers for Disease Control (CDC) guidelines, take specified actions regarding infection control measures.
- Requires each hospital, at least once every three years, to prepare a written report that examines the hospital's existing resources and evaluates the quality and effectiveness of the hospital's infection surveillance and prevention program.
- By January 1, 2008, requires the department to: (1) implement a Health Care Infection surveillance and prevention program; (2) investigate the development of electronic reporting databases and report its findings to the Advisory Committee; (3) revise

existing and adopt new administrative regulations, as necessary, to incorporate current Centers for Disease Control and Prevention guidelines and standards for health care infection prevention.

- Beginning January 1, 2008, requires 450 hospitals (General Acute Care) to report various data to the department, and the department must then make this information available to the public within 6 months.
- Appoint a “Health Care Associated Infection” Advisory Committee, as specified by July 1, 2007, that will make recommendations for the prevention and reporting of these infections.

Background—Concerns with Infections in Health Care Settings. According to the department, health care acquired infections are a major public health problem in California. California’s 450 hospitals account for an estimated 240,000 infections, 13,500 deaths, and \$3.1 billion dollars in excess healthcare costs annually. Many more infections occur in California’s 1,500 nursing homes and long-term care facilities, 800 Intermediate Care Facilities (ICFs), 600 ambulatory surgical centers, and 350 dialysis centers.

Legislative Analyst’s Office (LAO) Recommendation—Modify. The LAO recommends using Licensing and Certification (L&C) Fund support, in lieu of General Fund support for all *but* \$170,000 (General Fund). Therefore under this recommendation, fees to healthcare facilities would be increased to account for this shift. The L&C Funds would be used to support most of the positions within the Division of Communicable Disease (i.e., infection control and microbial diseases laboratory). A savings of \$1.4 million (General Fund) would be achieved by shifting to the L&C Fund.

The LAO contends that L&C Funds should be used for this purpose because the program will benefit hospitals by reducing their costs, ensuring the health and safety of patients, and providing technical assistance.

Subcommittee Staff Recommendation—Modify to Delete Two Positions. It is recommended to modify the budget request by deleting two positions within the Division of Communicable Disease. The positions recommended to delete are a Research Scientist III (Epidemiology Biostatistics) from the Infectious Disease Branch, and a Research Scientist III from the Microbial Diseases Laboratory. About \$200,000 in General Fund savings would be obtained, including operating expenses.

These positions are recommended to be reduced for several reasons. First, positions and funding were added last year in the Division of Communicable Disease to partially address overall infrastructure needs, including infectious diseases. As such, these positions can serve to facilitate progress on this issue area, particularly in the area of mitigating the spread of influenza.

Second, with the elimination of these two positions, there would still be other Research Scientist and data specialist positions provided, just not as many. Further as previously noted, there are two existing positions (Public Health Medical Officer III and a Nurse Consultant) doing infection control work. In addition, the CDC guidelines will serve as a core focal point for the development of the overall program. As such, information can be

obtained from the CDC in many areas.

Third, it is recommended not to shift a portion of the General Fund expenditures to L&C Fund support. Many of the activities to be conducted by the Division of Communicable Disease is public health related, including working with local health jurisdictions to mitigate the spread of communicable diseases within the community that can enter into a health care environment (such as a hospital or nursing home). As such, using fees for this purpose would be broadening the purpose of the fee.

Questions. The Subcommittee has requested the Department of Public Health to respond to the following questions.

1. Department of Public Health, Please provide a brief description of the key aspects of the enabling legislation and how the budget request is intended to implement it.

7. Hospitals Fair Pricing Policies—Assembly Bill 774 (Chan), Statutes of 2006

Issue. The budget proposes a total increase of \$699,000 (\$252,000 General Fund, \$195,000 L&C Fund, and \$252,000 federal funds) to support a total of 6 positions (two-year limited-term) to implement Assembly Bill 774 (Chan), Statutes of 2006. Among other things, this enabling legislation requires hospitals to maintain written policies about discount payment and charity care for financially qualified patients as one condition of licensure.

Of the total amount, the **Department of Health Care Services (DHCS)** is to receive \$504,000 (\$252,000 General Fund) to support **4.5 positions** (two-year limited-term) to audit hospitals' compliance with new pricing policies required for licensing as contained in the enabling legislation. The positions include four Health Program Auditor III positions and a half-time Health Program Auditor Manager.

The DHCS would use these positions to complete financial reviews of the hospitals (including general acute care, acute psychiatric, and special). These reviews would be done over three years (one third each year is 150 hospitals) and would include any issues regarding overpayments made by patients and remittance of any such over payments. The number of auditors requested for this purpose is consist with past workload calculation practices.

The remaining **\$195,000** (L&C Fund) is to support **1.5 positions** within the Department of Public Health (Licensing and Certification Division), including a half-time Staff Counsel position and a Health Facility Evaluator Nurse. These positions are requested to review hospital policies to ensure that they contain the prescribed components of law. The L&C Division states that these requirements will increase the survey time during licensing, renewal licensing, and complaint surveys. In addition, the partial Staff Counsel position is requested to develop and implement detailed policies to comply with the requirements, and to provide legal advice as issues of interpretation arise during enforcement actions.

Background—Assembly Bill 774 (Chan), Statutes of 2006. This enabling legislation requires hospitals to maintain written policies about discount payment and charity care for financially qualified patients as one condition of licensure. The Department of Health Care Services (DHCS) and the Department of Public Health (DPH) are required to enforce the provisions of this legislation and must ensure that any overpayment made by patients pursuant to this policy are returned to the patients.

Core requirements of this legislation include the following:

- Requires hospitals as a condition of licensure to maintain an understandable, written policy regarding discount payments for qualified persons, as well as a written charity care policy.
- Provides eligibility for a hospital's charity care or discount payment policies for uninsured patients or patients with inadequate insurance who are at or below 350 percent of poverty (\$70,000 for a family of four);
- Requires the DHCS and DPH to enforce the provisions of the legislation by ensuring

that fair pricing is applied to uninsured and underinsured patients along with discount payments to financially qualified patients, and to ensure that any overpayments are returned to the patient.

Legislative Analyst's Office Recommendation--Modify. The LAO is recommending to modify the proposal by (1) shifting all proposed expenditures to the L&C Fund, in lieu of General Fund support; and (2) reducing by one the DHCS requested positions (for a total of 3.5 positions) and making these audit positions permanent. The requested positions for the L&C Division within the Department of Public Health would be approved as proposed.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the proposal as budgeted. The positions as requested have been justified from a workload standpoint and it is recommended not to shift any additional expenditures to the L&C Fund. Funding audit positions with L&C Funds would be broadening the use of these funds.

Questions. The Subcommittee has requested the department to respond to the following questions.

1. Department, Please provide a brief summary of the key aspects of the enabling legislation and how the proposed budget would implement it.

8. Automated Drug Delivery System—Assembly Bill 2373 (Aghazarian), Statutes of 2006

Issue. The budget is requesting an increase of \$592,000 (L&C Fund) to support 4 (limited-term) positions to implement Assembly Bill 2373 (Aghazarian), Statutes of 2006 regarding automated drug delivery.

Specifically, the Licensing and Certification (L&C) Division is requesting the following positions:

- Two Pharmaceutical Consultant II's (one-year limited-term);
- A Pharmaceutical Consultant II (four-year limited-term); and
- An Office Technician (four-year limited-term).

The L&C Division states that key activities of these positions include the following:

- Review a facility's medication training, storage, security, and administrative procedures to ensure that safeguards are in place and drugs are delivered appropriately.
- Review and approve each submitted written request for utilization of an automated drug delivery system (ADDS) prior to implementation.
- Review on an annual basis during the certification survey the ADDS.
- Generate reports regarding approvals and denials, deficiencies and develop a tracking system plan review.

The L&C Division estimates that 15 percent of the 1,400 nursing homes, or 210 nursing homes, will use ADDS. Onsite inspection of the facilities using these systems must be conducted by a Pharmaceutical Consultant II

Background—Assembly Bill 2373 (Aghazarian), Statutes of 2006. This enabling legislation requires each nursing home facility planning to use an automated drug delivery system to notify the department prior to the utilization of the system, with information on its design, policy and procedures covering staff training, storage of drugs, and security measures. It will allow nursing homes to dispense multiple drugs at one time. (Presently, there are a few nursing homes that have devices that dispense only one drug at a time.)

Background—Automated Drug Delivery System (ADDS). ADDS are secure drug storage devices or cabinets that electronically dispense medications in a controlled fashion and track medication use. Their principal advantage lies in permitting licensed personnel to obtain medications for patients at the point of use.

These automated dispensing systems can be stocked by centralized or decentralized pharmacies. Most systems require user identifiers and have security systems to track personnel accessing the system.

With respect to usage in nursing homes, there are currently a few nursing homes that have

similar devices as part of a pilot program, but these devices only dispense one drug at a time.

Legislative Analyst's Office Recommendation—Modify Request. The LAO recommends: (1) deleting a Pharmacy Consultant position (limited-term) given that the estimated number of hours to complete specified one-time activities equates to one position; and (2) deleting the Office Technician position since their functions can be absorbed by other newly requested positions and existing positions with the L&C Division.

Subcommittee Staff Recommendation—Concur with LAO. It is recommended to adopt the LAO recommendation to delete a total of two positions, including the Pharmacy Consultant and the Office Technician positions.

Question. The Subcommittee has requested the department to respond to the following question.

1. L&C Division, Please provide a brief summary of the key components of the enabling legislation, and how the budget request implements it.